State of California
Department of Managed Health Care
HMO Help Center

To:	From:
Fax:	Fax: 916-229-4328
Pages: (including cover sheet)	Date:

INDEPENDENT MEDICAL REVIEW
REQUEST FOR HEALTH PLAN INFORMATION (RHPI)

The Department of Managed Health Care has received the attached request for an Independent Medical Review (IMR). In order to determine whether the applicant is eligible, the health plan is requested to provide information regarding the disputed health care service.

IMR Case # _____ Phone # _____

Complaint Analyst _____ Fax # **916-229-4328**

☐ **EXPEDITED REQUEST DUE _____** ☐ STANDARD REQUEST DUE _____

Reply Via Fax to DMHC: Fax # (916) 229-4328 no later than due date.
Please call the complaint analyst if you have any questions.

Name of Patient _____ Plan Coverage Type _____
(HMO, POS, PPO, etc.)

Name of Subscriber _____

Enrollee DOB: _____
(Only if Medi-Cal Managed Care beneficiary)

Membership ID#/SSN _____

Disputed Treatment _____

HEALTH PLAN INSTRUCTIONS

Documentation to be attached:

- ☐ All denial letters issued from medical group and plan
- ☐ Grievance letter from enrollee and plan's final grievance response specific to the disputed treatment
- ☐ If applicable, the treating physician's treatment authorization or medication request and health plan's denial.
- ☐ If the plan's decision was based, in whole or in part, on coverage, attach the relevant underlined segments of the applicable Evidence of Coverage.

Important Response Times: Health Plan response time back to DMHC for **Expedited Requests is 24 hours** from date of fax. Health Plan response time back to DMHC for **Standard IMR Requests is 2 business days** from date of the fax.

Health Plan to Complete All Items in this Section

1. The health plan's reason for denial was based on which of the following determinations: (Check the appropriate boxes)

Benefit / Coverage		**Medical Necessity**	
Experimental / Investigational Treatment		**ER / Urgent Care Reimbursement Denial**	

2. Does the health plan agree that this case is eligible for Independent Medical Review? ☐ **Yes** ☐ **No**

3. Is the enrollee/subscriber a commercial health plan member? ☐ **Yes** ☐ **No**

   If "No," please describe the type of coverage: _____

4. The date the grievance was received: _____ The date the grievance was resolved: _____

5. If the health plan believes the dispute has been resolved, please explain or attach relevant correspondence, include a copy of the authorization if the plan has reversed the initial denial of services.

6. Was the health plan grievance expedited? ☐ **Yes** ☐ **No**
   If "Yes," explain: _____

7. Has an in-plan provider seen the enrollee/subscriber for the medical condition or treatment? ☐ **Yes** ☐ **No**

8. Does the dispute involve a claim for reimbursement for non-emergent medical care? ☐ **Yes** ☐ **No**

9. Does the dispute involve whether services should be authorized from in-plan or out-of-network providers? ☐ **Yes** ☐ **No**

For Prescription Medication Disputes Only

1. Type of Prescription Benefit Dispute (Check all appropriate descriptions)

   ___ Off-Label Use ___ Compound Medication ___ Failed pre-authorization standards

   ___ Brand Name vs. Generic ___ Formulary medication required

   ___ Other: _____

2. If denial is based on required trial of alternative formulary medications, please list the formulary substitutes for the disputed prescription drug:
   _____

3. If applicable, please provide copies of relevant EOC applicable to the disputed prescription benefit, the policies relating to the specific medication, if any; pertinent correspondence between the plan, prescribing provider and enrollee concerning the medical necessity for the disputed medication and suggested alternatives.